(School District Name)
(Address)
(Address)
(Telephone)

CONSENT FOR RELEASE OF INFORMATION AND MEDICAID REIMBURSEMENT

Student's Full Name_____ **Student's Date of Birth**_____

Parent's Name_____ **Student's ID Number**_____

Student's Medicaid Number_____

_____ School District has my permission to release and exchange medical and other confidential information with the _____ (specify agency/organization) as necessary for the purpose of Medicaid billing for health-related services provided to my child. The records to be released/exchanged are listed as follows:

_____

_____

_____

_____

By signing this form, I give _____ School District my permission to bill Medicaid and receive payment from Medicaid for health-related services as set forth in my child's Individualized Educational Program (IEP) dated _____.

I understand that I will not be required to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services. I understand that Medicaid reimbursement for health-related services provided by _____ School District will not affect any other Medicaid services for which my child is eligible. I understand that my child's Medicaid benefits will not be used if the use will:

- decrease available lifetime coverage or any other insured benefit,
- result in my family paying for services that would otherwise be covered by the Medicaid program and that are required for my child outside the time my child is in school,
- increase premiums or led to the discontinuation of Medicaid benefits, or
- risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures

I understand that my child will receive the services listed in the IEP regardless of whether I enroll my child in public benefits programs. I also understand that my refusal to allow access to Medicaid reimbursement does not relieve the District of its responsibility to ensure that all required services are provided at no cost to me.

I understand that the granting of consent is voluntary on my part and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate any action that has occurred after the consent was given and before the consent was revoked).

I also understand that the _____ School District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding provision of health-related services to my child.

Signature_____ **Date**_____

Parent (or Student if over 18)